Department of Veterans Affairs
Medical Center
North 4815 Assembly Street
Spokane WA 99205-6197

February 26, 2009

Dear Editor:

As the Director of the Spokane VAMC, I have grown increasingly concerned with the tone recent articles in the Spokesman Review have taken in regard to suicides committed by veterans treated at our facility. Suicide is devastating for all involved. It is an irrevocable decision that forever alters families, and leaves surviving friends and family members consumed with guilt and a long list of "what ifs."

For a variety of reasons, the first 9 months of 2008 saw a spike in veteran suicides in this community and the surrounding areas. This sad reality has been mirrored in other parts of the country, among veterans, and by soldiers still actively enrolled in the military and therefore not yet being treated by the VA.

Each veteran has a specific set of circumstances that leads them to make this tragic decision. In regard to Spokane, some of those who died last year were being actively treated at this facility, some had received care here in the past, and some had never sought out VA services. Regardless of their treatment history, or lack thereof, we consider each death a tragedy and review them with utmost seriousness and a profound sense of respect. Such reviews include a thorough overview of treatment and medication histories, as well as provider interactions. We also consider missed appointments in the days and months prior to a death and whether or not our follow up efforts were sufficiently aggressive. When concerns regarding individual providers are identified, we review them carefully and take appropriate action.

The VA provider identified in the February 25, 2009 article has worked at the Spokane VA for 6 years. He is one of 7 psychiatrists at this facility who treat veterans suffering from PTSD, depression and other significant mental illnesses. During his tenure, he has helped hundreds of veterans. He is a dedicated provider, with excellent qualifications, and is extremely committed to his patients. He is a valuable member of our staff.

During the time the 2008 suicides occurred, Dr. Brown was assigned to Spokane's inpatient psychiatric service. This means that he regularly came in contact with the most troubled of our veterans. An unfortunate, tragic and often unacknowledged reality is that depression and PTSD can become chronic conditions that, like other chronic illnesses, may lead to increased mortality. It is also important to note that those who have been psychiatrically hospitalized have a higher rate of suicide than those who have not. Therefore, although Dr. Brown had contact with some of the veterans who later took their lives, the innuendo that he was responsible for these deaths is irresponsible.

VA believes that every veteran death is a tragedy, and as such, has aggressively sought to reduce the incidence of suicide. This includes suicide prevention and awareness training for every VA employee, the hiring of a suicide prevention coordinator at every facility, the activation of a national suicide prevention hotline (1-800-273-TALK, press 1 for veterans), a national website (www.suicidepreventionlifeline.org) and increased monitoring and outreach efforts for veterans identified as high risk. We also make every attempt to contact high risk veterans who miss appointments. Every employee at the Spokane VA is committed to reducing the incidence of suicide by using all tools available to us. We are also dependent on the support of our community to assist us in this critically important work.

//s//

Sharon Helman
Spokane VA Medical Center Director